NAME OF YOUR FACILITY: _____

## RESIDENT INFORMATION:

**Resident Name**: _____ **Age:** _____

**Diagnosis:**

_____

**Additional medical concerns: (Check all that apply)**

_____ Bedfast _____ Gastrostomy Tube _____ MRSA infection or other serious infection

_____ Requires oxygen _____ Requires intermittent positive pressure breathing equipment

_____ Tracheostomy _____ CPAP _____ Nebulizer treatments

_____ Colostomy _____ Ileostomy _____ Foley Catheter _____ Suprapubic Catheter

_____ Bowel incontinence _____ Urinary incontinence

_____ Contractures _____ Diabetic _____ Requires routine Accu-check or Glucose testing

_____ Open wounds _____ Pressure or Stasis Ulcers

_____ Requires regular intramuscular, subcutaneous or intradermal injections

_____ Requires protective supervision

**Name of Hospice Agency providing resident care**: _____

**Telephone #** _____

**Name of Home Health Agency providing resident care**: _____

**Telephone #** _____

Signature of Administrator: _____

Print Name of Administrator: _____

Date: _____